



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DALLAS SPINE CARE  
C/O ROYCE BICKLEIN  
4800 EAST 42<sup>ND</sup> ST SUITE 300  
ODESSA TX 79762

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

INSURANCE CO OF NORTH AMERICA

#### **Carrier's Austin Representative Box**

Box Number 15

#### **MFDR Tracking Number**

M4-08-5819-01

#### **MFDR Received Date**

JANUARY 18, 2007

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "On December 8, 2005, the Carrier's Pre-Authorization agent approved a second follow-up surgery because of a Dural Tear. On January 19, 2006, Dr. Henderson performed the second spinal surgery. It is operation of Bad Faith and Fraudulant [sic] practices on the part of the Carrier to Pre-Authorize something, with a peer-review in hand, and then deny payment on the basis of treatment being unnecessary."

On February 2, 2007 the requestor's agent submitted a supplemental letter which states: "Pursuant to our phone conversation from earlier today, please be advised that pursuant to the Divisions newest Rules, I hereby withdraw my request for MDR/IRO on any and all services which fall outside those services that were already pre-authorized. In other words, I wish to make my previous MDR filings to be about payment disputes for services that were originally pre-authorized by the Carrier and then denied for payment."

**Amount in Dispute:** \$43,992.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Based on Peer Review dated 8/17/05 on going medical treatment did not appear to be reasonable & necessary -"

**Response Submitted by:** ESIS, PO Box 31108, Tampa FL 33631

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2005 through December 7, 2005	99213, 99214, 99361, 63045, 64623, 63047, 63707, 22830, 22852, 64622, 95920-26, 95937-26,	\$34,484.50	\$0.00
January 18, 2006 January 19, 2006 April 5, 2006 May 3, 2006 June 21, 2006, July 19, 2006 August 9, 2006 September 20, 2006	CPT Code 63709, 95937-26 and 95920-26 CPT Codes 99212, 99213 and 99214	\$9,507.50	\$1,230.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization of certain services.
3. 28 Texas Administrative Code §133.305 sets out the guidelines for Medical Dispute Resolution, General.
4. 28 Texas Administrative Code §134.202 sets out the guidelines for payment of
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 9, 2006, March 9, 2006, May 16, 2006, September 14, 2006, September 26, 2006, September 28, 2006, and November 10, 2006,

- W9 – Unnecessary medical treatment based on peer review.
- (880-139) – Reimbursement has been denied based upon the recommendation of a peer review 100%.
- 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- 45 – Charges exceed your contract/legislated fee arrangement.
- (100) – Any network reduction is in accordance with the Network referenced above.
- (113-001) – Network import re-pricing – contracted provider.

### **Issues**

1. Did the requestor submit the disputed dates of service in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit the disputed dates of service to the proper venue in accordance with 28 Texas Administrative Codes §§133.305 and 133.308?
3. Did the requestor obtain preauthorization in accordance with 28 Texas Administrative Code §134.600 for date of service January 19, 2006?
4. Was the requestor reimbursement in accordance with 28 Texas Administrative Code §134.202?
5. Is the requestor entitled to reimbursement?

### **Findings**

1. Per 28 Texas Administrative Code §133.307(d)(1)A request for medical dispute resolution on a carrier denial or reduction of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials) or an employee reimbursement request shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The request for medical fee dispute resolution was received in the Division on January 18, 2007. The request did not meet the timely filing requirements of the rule, therefore, disputed dates of service September 1, 2005 through November 16, 2005 are not eligible for review.

Per 28 Texas Administrative Code § 133.307(e)(2)(A) states, in part, that all provider and carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission. Each copy of the request shall be legible, include only a single copy of each document, and shall include a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304. The medical bills submitted with the request for medical fee dispute resolution did not contain bills for dates of service January 18, 2006, June 21, 2006, July 19, 2006, August 9, 2006 and September 20, 2006. The requestor did not meet the requirements of the rule and these dates of service are not eligible for review.

2. The insurance carrier reduced or denied disputed services billed on April 5, 2006 and May 3, 2006 with reason code 45 – “Contract/Legislated Fee Arrangement Exceeded” (100) – “Any network reduction is in accordance with the network referenced above” and (113-001) – “Network import re-pricing – contracted provider.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

The insurance carrier also denied the disputed dates of service of April 5, 2006 and May 3, 2006 with reason codes W9 – “Unnecessary medical treatment based on peer review” and (880-139) – “Reimbursement has been denied based upon the recommendation of a peer review 100%.” In accordance with 28 Texas

Administrative Code §133.305(a)(4)(A) retrospective necessity disputes involve a review of the medical necessity of health care provided. The dispute is reviewed by an independent review organization pursuant to commission rules, including §133.308 of this title. The following type of dispute may be retrospective necessity Dispute: a health care provider dispute of a carrier denial of a medical bill based on lack of medical necessity. Therefore, these services fall under the provisions of 28 Texas Administrative Code §133.308 and are not reviewable by Medical Fee Dispute Resolution.

3. The insurance carrier reduced or denied disputed services billed on January 19, 2006 with reason code 62 – “Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.” According to the preauthorization approval dated December 8, 2005, preauthorization number PH 271332A, Intracorp received the requests for Repair of Dural Tear, decompression revision and 3 inpatient days in an acute hospital setting. A verbal approval, per Physician Advisor, was given to Amada/Robert Henderson, MD. The start date on the preauthorization approval was December 2, 2005 and the end date was January 15, 2006.
4. In accordance with § 134.202(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section; and (c)(1) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%.
  - CPT Code 63709 is defined as a repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy. The facility price of this code is \$984.00 multiplied by 125% equals a payment amount of \$1,230.00. Review of the operative report supports reimbursement is warranted.
  - CPT Code 95920-26 is a component procedure of CPT Code 63709 and considered bundled. A modifier is not allowed. Therefore, reimbursement is not warranted.
  - CPT Code 95937-26 is a component procedure of CPT Code 63709 and considered bundled. A modifier is not allowed. Therefore, reimbursement is not warranted.
5. Review of the submitted documentation finds that reimbursement for the primary procedure code is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,230.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,230.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	<u>November 15, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	<u>November 15, 2012</u>
Signature	Medical Fee Dispute Resolution Manager	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**